Republic of Kenya

Ministry of Health

MONITORING AND EVALUATION FRAMEWORK 2014/15–2018/19

For Kenya AIDS Strategic Framework
2014/15-2018/19

maisha!
National AIDS Control Council
www.nacc.or.ke

MONITORING AND EVALUATION FRAMEWORK

2014/15–2018/19

For Kenya AIDS Strategic Framework
2014/15-2018/19

National AIDS Control Council

www.nacc.or.ke

> The framework, managed by the National AIDS Control Council, draws from the different M&E sub-systems that report on various aspects of the response. It further leverages on the use of technology to enhance timely reporting and improve data management.

CONTENTS

ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
BSS	Behavioral Surveillance Survey
CASCO	County AIDS and STI Coordinating Officer
CBIS	Community-Based HIV Information System
CBO	Community-Based Organization
CHW	Community Health Worker
CHEW	Community Health Extension Worker
CHIS	Community Health Information System
COBPAR	Community-Based HIV and AIDS Activity Reporting
CSOs	Civil Society Organizations
DHS	Demographic and Health Survey
DHIS	District Health Information System
DQA	Data Quality Assurance
GARPR	Global AIDS Response Progress Reporting
GBV	Gender Based Violence
HMIS	Health Management Information System(s)
IBBS	Integrated Biological and Behavioural Survey
ICC	Interagency Coordinating Committee
KAIS	Kenya AIDS Indicator Survey
KNASA	Kenya AIDS Spending Assessment
KASF	Kenya AIDS Strategic Framework
KNASP	Kenya AIDS Strategic Plan
KNBS	Kenya National Bureau of Statistics
KP	Key Population
LMIS	Logistics Management Information System
MDAs	Ministries, Departments, and Agencies
MoH	Ministry of Health
MSM	Men Who Have Sex With men
M & E	Monitoring and Evaluation
NASCOP	National AIDS and STI Control Program
NACC	National AIDS Control Council
NCPD	National Council for Population and Development
NCPI	National Composite Policy Instrument
NGO	Non-Government Organisation
PBS	Pooling Both Survey
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PEP	Post-exposure Prophylaxis
PSHIS	Private Sector HIV Information System
PWIDS	People Who Inject Drugs
SARAM	Service Availability and Readiness Assessment
SD	Strategic Direction
SRH	Sexual and Reproductive Health
UHRIS	Unified HIV Response Information System
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USG	United States Government
WHO	World Health Organisation

FOREWORD

This One Country M&E Framework has been prepared to guide all the stakeholders, implementers and partners in the HIV response, in monitoring and evaluating their programmes in order to: a) provide the required information for decision making at all levels and, b) track progress and continuously measure results towards achieving the objectives of the Kenya AIDS Strategic Framework (KASF) 2014/15 - 2018/19. It is aimed at improving efficiency of the response, enhancing transparency of all players and strengthening accountability in the implementation of KASF. It is therefore a management and governance tool.

This framework is aligned to Kenya's new governance structure as articulated in the Constitution of Kenya 2010. National and County governments are integral to the attainment of the M&E goals outlined herein. The M&E framework therefore provides mechanisms for communication and information sharing between the two levels of government.

It should be emphasised that the indicators in this framework are core to implementation and review of performance under KASF. Therefore, all stakeholders including, Government Ministries and Agencies, Counties, Implementing and Development Partners, Civil Society, Faith Based Organisations and the Private Sector are encouraged to use the core indicators captured in this framework as the minimum for KASF.

The framework, managed by the National AIDS Control Council, draws from the different M&E sub-systems that report on various aspects of the response. It further leverages on the use of technology to enhance timely reporting and improve data management. To this end, stakeholders will establish a common web-based database on core indicators for use. This tool will also enhance data sharing and production of M&E products.

The framework also provides a robust approach for evaluation of KASF. Critical surveys, evaluations and surveillance will be undertaken to measure outcomes and impact of the strategic framework.

All stakeholders are urged to adopt and implement this M&E Framework, align their internal M&E systems to this framework, and be committed to report through the national systems outlined in the framework.

Rev. Canon Rosemary Mbogo
Ag. Chairperson, National AIDS Control Council

Rev. Canon Rosemary Mbogo

Ag. Chairperson,
National AIDS Control Council

ACKNOWLEDGEMENT

Dr. Nduku Kilonzo,

Director,
National AIDS Control Council

The National AIDS Control Council (NACC) acknowledges the contributions of the Joint United Nations Programme on HIV and AIDS (UNAIDS), United Nations Population Fund (UNFPA), World Health Organization (WHO), United Nations Children's Fund (UNICEF), the U.S. Government (USG), and other partners, who provided invaluable technical support and financial resources toward this process.

Sincere gratitude goes to the experts from different institutions who worked tirelessly to complete this monitoring and evaluation framework including: Joshua Gitonga, Regina Ombam, Steve Kathaka and Mercy Khasiani (National AIDS Control Council), Dr. Joyce Wamicwe and Dr. Jacob Odhiambo (National AIDS and STIs Control Programme), Parinita Bhattacharjee (UoN) Dr. Davies Kimanga (EGPAF), George Owiso (itech-Kenya) Dr. Brian Pazvakavambwa (WHO), Dr. Geoffrey Okumu (UNFPA), Ruth Laibon-Masha and Gurumurthy Rangaiyan (UNAIDS), Onesmus Mlewa (Kenya AIDS NGOs Consortium), Lize Ojowi (U.S. Agency for International Development); and members of the M&E Technical Working Group (please see the full list in Annex 3).

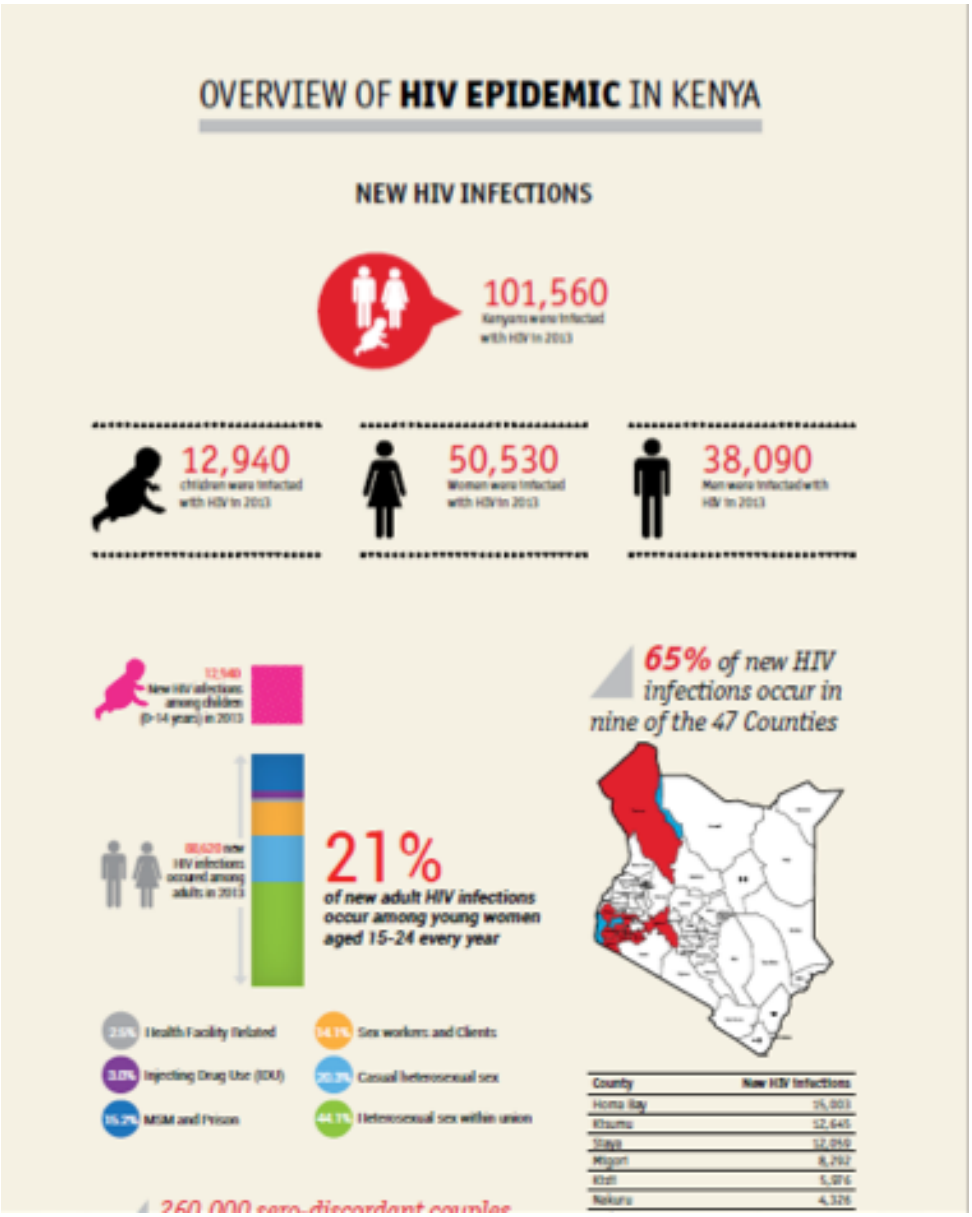
Finally, our gratitude goes to the AIDS, Population, and Health Integrated Assistance Evaluation project for supporting the editing, designing, and printing of this framework; and Tom Mogeni, who was the consultant supporting the development of this framework.

Dr. Nduku Kilonzo,
Director, National AIDS Control Council

SECTION

01

INTRODUCTION



1.1 Background

The One Country M&E Framework is aligned to the new governance structure in the country in line with the Constitution of Kenya 2010. National and County governments are key to the attainment of the M&E goals outlined herein. The framework therefore provides mechanisms for communication and information sharing between the two levels of government.

It should be emphasised that the indicators in this framework are core, and therefore, all stakeholders, including, Government Ministries and Agencies, Counties, Implementing and Development Partners, Civil Society, Faith Based Organisations and the Private Sector, are encouraged to use this framework in defining the minimum set of indicators required for monitoring and evaluating the attainment of the objectives of the Kenya AIDS Strategic Framework (KASF).

This framework, managed by the National AIDS Control Council (NACC), draws from the different M&E sub-systems that report on various aspects of the HIV response. It further leverages on the use of technology to enhance timely reporting and improve data management. To this end, stakeholders will establish a common web-based database on core indicators for use. This tool will also enhance the production of M&E products and sharing of data and products to facilitate efficient and effective decision making at all levels.

The framework also provides a robust approach for evaluation of KASF. Critical surveys, evaluations and surveillance will be undertaken to measure outcomes and impact of the strategic framework.

All stakeholders are urged to adopt and implement this M&E Framework, align their internal M&E systems to this framework, and be committed to reporting through the national systems outlined in the framework.

1.2 Objectives of the M&E Framework

The purpose of this M&E framework is to facilitate the tracking of progress towards KASF results and generation of strategic information to inform decision making by stakeholders at national and county levels.

Specific objectives of the framework are:

1. To define the data requirements and assign responsibilities for effective tracking of KASF implementation at all levels.
2. To define data management protocols and assign responsibilities for data collection, data flow, analysis and reporting by different stakeholders at national and county levels.
3. To define data feedback mechanisms and utilisation for decision making at national and county levels and among stakeholders.

1.3 Guiding Principles of the M&E Framework

This M&E framework is anchored on the overarching internationally agreed "three ones" principle in addressing the HIV and AIDS epidemic, which emphasises the need for having One Country M&E System for effective coordination. The implementation of the framework will be guided by the following principles:

1. **Harmonisation and alignment:** All government agencies at national and county level as well as private, civil society and faith based implementing organisations and partners will collaborate to attain KASF results in a harmonised and coordinated manner. This M&E framework will therefore provide guidance to enable implementing organisations and supporting partners to harmonise their

data and M&E processes and work collaboratively to facilitate an efficient and coordinated process of tracking, monitoring and evaluating KASF results.

2. **Standardisation of indicators and data collection:** KASF indicators, data collection tools, and methods have been standardised to allow comparability of KASF outputs and outcomes across counties and between sectors.
3. **Strategic dialogue and partnerships:** Dialogue and partnerships will be strengthened through various stakeholder fora at national and county levels to review progress in the KASF implementation and assess the effectiveness of HIV programmes.
4. **Data demand and use:** Data collected at all levels will be made available to both national and county governments for use in decision making and programming of HIV interventions.
5. **Transparency, accountability and feedback:** Information dissemination mechanisms will be utilised to promote transparency and enhance accountability at national and county levels, taking advantage of information technology to enhance efficiency. Some of these mechanisms will therefore include online and media channels.

1.4 Process of Developing the Framework

Development of this framework was undertaken through a wide participatory and consultative process, which is in line with the multi-sectoral nature of HIV and AIDS response. A multisectoral constituted M&E technical working group, which included government agencies, development partners, professional bodies and institutions and implementers, spearheaded the development process. The process was largely informed by a strategic review of the M&E of HIV and AIDS in Kenya. Various consultative fora were held with stakeholders to discuss the draft plan and select national indicators for tracking the HIV response. The previous M&E Framework and International M&E indicators from sources such as the Global AIDS Response Progress Reporting (GAPR), the President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund and Universal Access target largely informed the development of this M&E Framework. County representatives participated throughout the framework's development process.

SECTION

02

CORE KASF INDICATORS

2.1 Introduction

This section outlines the core indicators to be used in monitoring, tracking and evaluating the KASF outputs, outcomes, and impact, and to inform decision making at national and county levels. The indicators measure the performance of KASF in line with the set goal and the targeted results for each strategic direction. However, through development of specific plans to implement KASF, counties and other stakeholders will identify additional indicators to meet their information requirements.

2.2 KASF Impact Level Results and Indicators

The KASF has defined the following impact level results to be achieved by 2019:

- Reduce new infections by 75%.
- Reduce AIDs related mortality by 25%.
- Reduce HIV related stigma and discrimination by 50%.
- Increase domestic financing of the HIV response to 50%.

Table 1 shows the indicators that will be used to track the impact level results of KASF, the sources of data, timelines and institutions responsible for reporting.

Table 1: KASF Impact Indicators

Objective	Indicator	Data Source	Responsible Institution
Reduce new infections by 75%	Number of new adult HIV infections disaggregated by gender and age	HIV estimate (Spectrum modeling)	NACC
	Percentage of young women and men ages 15–24 who are HIV infected	KDHS, KAIS HIV estimate (Spectrum modeling)	NACC
	Percentage of child infections from HIV-infected women delivering in the past 12 months	HIV estimate (spectrum modeling)	NACC
	Number of new child HIV infections	HIV estimate (Spectrum modeling)	NACC
	Estimated annual number of new infections from KP's (sex workers, men who have sex with men [MSMs], prison populations, PWIDs)	Mode of transmission study	NACC
Reduce HIV-related mortality by 25%	Number of HIV-related deaths disaggregated by gender and age	HIV estimate (Spectrum modeling)	NACC
Reduction of stigma and discrimination by 50%	Percentage of women and men aged 15–49 who report discriminatory attitudes towards persons living with HIV/AIDS (PLHIV)	KDHS, KAIS	NACC
	Percentage of PLHIV who report having experienced discriminatory attitudes	Stigma Index Survey	NACC
Increase domestic funding for the HIV response to 50%	Percentage of funding for the HIV response coming from the government	KNASA, Annual multi-sector expenditure reports	NACC

2.3 Indicators for KASF Strategic Directions

2.3.1 Strategic Direction 1: Reducing New HIV Infections

This strategic direction addresses the complex patterns of the HIV epidemic characterized by high HIV prevalence and incidence among the key populations and high vulnerability of women, adolescents, and couples to HIV infection and geographical disparities of the epidemic. Under this strategic direction, implementation of KASF will be augmented by the following strategic and operational documents: (1) the Kenya HIV Prevention Roadmap, (2) The strategic framework for Elimination of Mother to Child Transmission of HIV and Keeping Mothers Alive 2012–2015, (3) A strategic framework for Engagement of the First Lady in HIV Control and Promotion of Maternal, Newborn and Child Health in Kenya 2013–2017, (4) National guidelines for HIV testing and counselling for couples and prevention with positives, and (5) Policy analysis and advocacy decision models for services for key populations in Kenya. These strategic and operational documents contain detailed indicators for tracking progress and results that will provide additional information to the KASF core indicators.

This section outlines two (2) KASF priority results and thirty two (32) core indicators for measuring achievement of the results and tracking progress in implementation of priority interventions under this strategic direction. The expected priority results under this strategic direction are as follows:

- Reduced annual new HIV infection among adults by 75%
- Reduced mother to child HIV transmission rate from 14% to less than 5%

Table 2 outlines the indicators against each priority result and service delivery area, sources of data, timeframe and institutions responsible for reporting.

Table 2: Indicators for KASF Strategic Direction 1: Reducing New HIV Infections

KASF Result	Service Delivery Area	Indicator	Data Source	Responsible Institution
Reduced new infections among adults by 75%	**Biomedical Interventions**			
	Adolescent programme	***SD1-1:*** Percentage of young women and men ages 15–24 who have had sexual intercourse before age 15	KDHS/KAIS	NACC
	PWID programme	***SD1-2:*** Number of syringes distributed per person who injects drugs by the Needle and Syringe Programme	Programme records	NASCOP
		SD1-3: Number of injecting drug users on opioid substitution therapy	Programme reports	NASCOP
	VMMC programme	***SD1-4:*** Number of males circumcised as part of the minimum package for male circumcision for HIV prevention services	Programme records	NASCOP
	Counseling and testing	***SD1-5:*** Number of People Counseled and Tested for HIV and who received their test results	Programme records	NASCOP
	Post-exposure prophylaxis (PEP)	***SD1-6:*** Number of sexual and gender-based violence (SGBV) survivors provided with PEP	DHIS	NASCOP
	Pre-exposure prophylaxis (PrEP)	***SD1-7:*** Number of people provided with PrEP	DHIS	NASCOP

KASF Result	Service Delivery Area	Indicator	Data Source	Responsible Institution
	Behavioral Interventions			
	General population	***SD1-8:*** Percentage of women and men ages 15–49 years who had sexual intercourse with more than one partner in the last 12 months	DHS/KAIS	NACC
		SD1-9: Percentage of women and men ages 15–49 years who had sexual intercourse with more than one partner in the last 12 months AND reported use of a condom during the last sexual encounters	DHS/KAIS	NACC
		SD1-10: Number of people from targeted audience reached through community outreach by at least one HIV information, communication or behavior change communication	Programme records	NACC
	Key population programme	***SD1-11:*** Percentage of male and female sex workers reporting the use of a condom during penetration sex with their most recent client	DHS/KAIS	NACC
		SD1-12: Percentage of men reporting use of a condom last time they had anal sex with a male partner	IBBS	NASCOP
		SD1-13: Percentage of people who inject drugs who reported use of a condom the last time they had sexual intercourse	IBBS	NASCOP
		SD1-14: Number and percentage of key populations reached with HIV prevention programmes	DHIS	NASCOP
	School health programme	***SD1-15:*** Number of adolescents ages 10–24 reached through life skills-based HIV education in schools	Ministry of Education report	Ministry of Education
		SD1-16: Percentage of adolescents ages 10-24 years having correct knowledge of how HIV is transmitted	KDHS	NACC
	Structural Interventions			
	PEP	***SD1-17:*** Percentage of health facilities providing PEP Services	DHIS	NASCOP
		SD1-18: Percentage of new infections resulting from medical sources disaggregated by survivors, SV and health personnel	MOTS/KAIS	NASCOP
	Leverage opportunities through creation of synergies with counties and other sectors for HIV prevention	***SD1-19:*** Number of national government ministries, departments, and agencies (MDAs) with results-based HIV plans aligned to KASF	Program records	NACC and county governments (HIV coordination unit)
		SD1-20: Number of county MDAs with results-based HIV plans aligned to KASF		

KASF Result	Service Delivery Area	Indicator	Data Source	Responsible Institution
Reduced HIV transmission rates from mother to child from 14% to less than 5%	**Biomedical Intervention**			
	Prevention of mother-to-child transmission (PMTCT) programme	***SD1-21:*** Estimated percentage of child infections from HIV-infected women delivering in the past 12 months	HIV estimates	NACC
		SD1-22: Number and percentage of pregnant women attending antenatal care (ANC) whose male partners were tested for HIV	DHIS	NASCOP
		SD1-23: Number and percentage of infants born to HIV-infected women who receive a virological test for HIV within 2 months of birth	DHIS	NASCOP
		SD1-24: Number and percentage of infants born to HIV-infected women starting on cotrimoxazole prophylaxis within 2 months of birth	DHIS	NASCOP
		SD1-25: Number and percentage of pregnant women who know their HIV status	DHIS	NASCOP
		SD1-26: Percentage of HIV positive pregnant women who received anti-retroviral medication to reduce the risk of mother-to-child transmission	DHIS	NASCOP
	Behavioral Intervention[1]			
	PMTCT programme	***SD1-27:*** Percentage of new ANC clients seen at health facility	DHIS	NASCOP
		SD1-28: Percentage of clients whose male partners were tested in maternal and child health (MCH) services	DHIS	NASCOP
		SD1-29: Percentage of clients who finished four ANC visits	DHIS	NASCOP
	Structural Interventions			
	Health systems strengthening	***SD1-30:*** Percentage of health facilities providing early infant diagnosis	DHIS	NASCOP

2.3.2 Strategic Direction 2: Improving Health Outcomes and Wellness of All People Living with HIV

This strategic direction aims to ensure prompt linkage to and retention in HIV care services among those diagnosed with HIV infection; timely treatment initiation for those eligible to achieve optimal viral suppression; and improved quality of care and treatment outcomes. The focus of this strategic direction is to put the country on the path to achieving, by 2020, the HIV treatment targets of 90% of all people living with HIV diagnosed, 90% of all people with diagnosed HIV infection put on anti-retroviral therapy, and 90% of all people receiving antiretroviral therapy having viral suppression.

Table 3 outlines six (6) KASF Results, the Service Delivery Areas and the related thirteen (13) core indicators that will be used to track the results of Strategic Direction 2 on improving health outcomes and wellness of all people living with HIV, their data sources, timeframe and institutions responsible for reporting.

[1] Indicators from the Strategic Framework for EMTCT in Kenya 2012–2015. Proxy indicators for behavioural interventions.

Table 3: Indicators for KASF Strategic Direction 2—Improving Health Outcomes and Wellness of all People Living with HIV

KASF Result	Service Delivery Area	Indicator	Source	Responsible Institution
Biomedical Interventions				
Increased linkage to care within 3 months of HIV diagnosis to 90% for children, adolescents, key populations, and adults	Antiretroviral treatment (ART) programme	***SD2-1:*** Percentage of people diagnosed HIV positive linked to care within 3 months	DHIS	NASCOP
	ART programme	***SD2-2:*** Percentage of people living with HIV (PLHIV) receiving HIV care services	DHIS	NASCOP
Increased ART coverage to 90% for children, adolescents, key populations, and adults	ART programme	***SD2-3:*** Number and percentage of adults and children enrolled in HIV care and eligible for cotrimoxazole prophylaxis currently receiving cotrimoxazole prophylaxis	DHIS	NASCOP
	PMTCT programme	***SD2-4:*** Number of eligible clients newly initiated on highly active ART in the last 12 months	DHIS	NASCOP
	ART programme	***SD2-5:*** Percentage of adults and children currently receiving ART among all eligible people living with HIV (using national criteria)	DHIS	NASCOP
	HIV/TB co-morbidity	***SD2-6:*** Percentage of TB/HIV co-infected clients who are receiving ARTs	DHIS	NASCOP
		SD2-7: Percentage of HIV patients screened for TB	DHIS	NASCOP
Increased retention on ART at 12 months to 90% in children, adolescents, key populations, and adults	ART programme	***SD2-8:*** Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (24 months, 36 months, 60 months)	DHIS	NASCOP
Increased viral suppression to 90% 12 months after initiation of ART for children, adolescents, key populations, and adults	ART programme	***SD2-8:*** Percentage of ART patients with an undetectable viral load at 12 months after initiation of ART	DHIS	NASCOP
		SD2-9: Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	DHIS	NASCOP
Structural Interventions				
Improved quality of care and treatment outcomes	Capacity building	***SD2-10:*** Percentage of health facilities providing HIV care and treatment services	DHIS	NASCOP
		SD2-11: Percentage of health facilities implementing continuous quality improvement activities according to MoH standardised protocols	DHIS	NASCOP
	ART programme	***SD2-12:*** Percentage of health facilities dispensing ART that have experienced a stock out of at least one required antiretroviral drug in the last 12 months	DHIS	NASCOP
		SD2-13: Number of health facilities providing care and treatment according to MoH standardised protocols	DHIS	NASCOP
Behavioral Interventions				
Improved community-based adherence support	HIV treatment literacy	***SD2-14:*** Number of PLHIV organisations reporting on treatment education programmes	COBPAR	NACC

2.3.3 Strategic Direction 3: Using a Human Rights Approach to Facilitate Access to Services for PLHIV, Key Populations and Other Priority Groups in All Sectors

This strategic direction is geared towards improving the legal and policy environment for a robust HIV response at the national and county level, and will facilitate access to HIV services by PLHIV, key populations, and other priority groups. The strategic direction is anchored on Article 27 of the Constitution of Kenya, which outlaws discrimination on the basis of one's health status, provides for equality between men and women, and allows affirmative action to protect and promote the rights of vulnerable populations. The strategic direction prioritizes the removal of barriers to access to HIV and sexual and reproductive health (SRH) services, improving policies and legal frameworks, reducing HIV-related stigma and discrimination, reducing gender-based violence, and improving access to legal and social justice. The following results have been defined by KASF:

- Reduced self-reported stigma and discrimination related to HIV and AIDS by 50%
- Reduced levels of sexual and gender-based violence for PLHIV, key populations, women, men, boys and girls by 50%
- Increased protection of human rights and improved access to justice for PLHIV, key populations, and other priority groups, including women, boys and girls
- Reduced social exclusion for PLHIV, key populations, women, men, boys and girls by 50%

Table 4 outlines five (5) KASF Results, the service delivery areas and the related twenty (20) core indicators that will be used to track the results of Strategic Direction 3, sources of data and the institutions responsible for reporting.

Table 4: Indicators for KASF Strategic Direction 3 - Using a Human Rights Approach to Facilitate Access to Services for PLHIV, Key Populations, and Other Priority Groups in All Sectors

KASF Result	Service Delivery Area	Indicator	Data Source	Responsible Institution
Behavior Interventions				
Reduced self-reported stigma and discrimination related to HIV and AIDS by 50%	Stigma and discrimination	***SD3-1:*** Percentage of PLHIV who self-reported that they experienced discrimination and/or stigma due to their HIV status	Stigma and discrimination index survey report	NACC
		SD3-2: Percentage of women and men ages 15–49 expressing accepting attitudes towards people living with HIV	KDHS/KAIS	NACC

KASF Result	Service Delivery Area	Indicator	Data Source	Responsible Institution
Reduced levels of sexual and gender-based violence against PLHIV, key populations, women, men, boys and girls by 50%	General population	***SD3-3:*** Percentage of ever married or partnered women and men ages 15–49 who experienced sexual and/or gender-based violence	KDHS/KAIS	NACC
		SD3-4: Percentage of young people ages 15–24 who experienced sexual and/or gender-based violence	KDHS/KAIS	NACC
	PLHIV	***SD3-5:*** Percentage of PLHIV who experienced sexual and/or gender-based violence	KDHS/KAIS	NACC
		SD3-6: Percentage of PLHIV ages 15–49 who experienced sexual and/or gender-based violence	DHS/KAIS	NACC
	Key populations	***SD3-7:*** Percentage of PWID who experienced sexual and/or gender-based violence	IBBS	NASCOP
		SD3-8: Percentage of men who have sex with men (MSM) who experienced sexual and/or gender-based violence	IBBS	NASCOP
		SD3-9: Percentage of sex workers who experienced sexual and/or gender-based violence	IBBS	NASCOP
		SD3-10: Percentage of children, 18 years and below, who experienced sexual and/or gender-based violence	VAC	
Reduced social exclusion for PLHIV, key populations, women, men, boys and girls by 50%	Key populations	***SD3-11:*** Percentage of sex workers reached with HIV prevention programmes	IBBS	NACC
		SD3-12: Percentage of MSM reached with HIV prevention programmes	IBBS	NACC
		SD3-13: Percentage of PLHIV and key populations reached with targeted HIV prevention treatment and social protection programmes	IBBS	NASCOP
	Remove barriers to access of HIV, SRH, and rights information and services in public and private entities	***SD3-14:*** Number of PLHIV and key affected populations reached with information on HIV, SRH, and rights	DHIS	NASCOP

KASF Result	Service Delivery Area	Indicator	Data Source	Responsible Institution
Structural Interventions				
Increased protection of human rights and improved access to justice for PLHIV, key populations, women, boys and girls	Human rights and improved access to justice	***SD3-15:*** Number of cases filed by PLHIV at the HIV Tribunal	HIV tribunal Records	HIV Tribunal
		SD3-16: Number of PLHIV and key population accessing legal services at the HIV tribunal	HIV tribunal Records	HIV Tribunal
		SD3-17: Number SGBV survivors accessing legal services	Judiciary records	Judiciary
	Improve national and county legal and policy environment for protection of PLHIV, key populations, women, boys, and girls	***SD3-18:*** Number of laws, regulations, and policies reviewed or enacted at county level that impact on the HIV response positively	County HIV reporting	NACC
		SD3-19: Number of laws, regulations, and policies reviewed or enacted at national level that impact on the HIV response positively	National Level HIV reporting	NACC
Reduced self-reported stigma and discrimination related to HIV and AIDS by 50%	Stigma, discrimination	***SD3-20:*** Number of counties implementing anti-stigma and anti-discrimination measures recommended in KASF	County HIV reporting	NACC

2.3.4 Strategic Direction 4: Strengthening Integration of Community and Health Systems

This strategic direction aims to build a strong and sustainable system for HIV service delivery at both national and county level through specific health and community systems approaches, actions and interventions. The following results have been defined by KASF:

- Improved health workforce for the HIV response at both county and national levels by 40%
- Increased percentage of health facilities ready to provide Kenya Essential Package for Health (KEPH)-defined HIV and AIDS services from 67% to 90%
- Strengthened HIV commodity management through effective and efficient management of medicine and medical products
- Strengthened community-level AIDS competency

Table 5 outlines the four (4) KASF Results, Intervention Delivery Area, and the related six (6) core indicators, which will be used to track the results of Strategic Direction 4, sources of data, and the institutions responsible for reporting.

Table 5: Indicators for Strategic Direction 4 - Strengthening Integration of Community and Health Systems

KASF Result	Intervention Delivery Area	Indicator	Data Source	Responsible Institution
Increased health workforce for the HIV response at both county and national levels by 40%	Health Care Workforce	***SD4-1:*** Ratio of cadres of health care staff to population in line with staffing norms	SARAM	NASCOP
Increased number of health facilities ready to provide KEPH-defined HIV and AIDS services from 67% to 90%	Health Facilities	***SD4-2:*** Percentage of health facilities providing KEPH-defined HIV&AIDS services	SARAM	NASCOP
Strengthened HIV commodity management through effective and efficiency management of medicine and medical products	Commodity Management	***SD4-3:*** Percentage of health facilities dispensing ART that experienced a stock-out of ARVs at least once in the last 12 months	SARAM	NASCOP
Strengthened community-level AIDS competency	Community Units	***SD4-4:*** Number of community units implementing AIDS competency guidelines	HMIS	NASCOP
	Community Based Organisations	***SD4-5:*** Number of Community Health Units given training on HIV module	COBPAR	NACC
		SD4-6: Number of Community Health Workers reporting on HIV programmes		
		SD4-7: Number and percentage of community-based organisations that submit timely, complete, and accurate reports according to guidelines	COBPAR	
	Health Systems Strengthening	***SD4-8:*** Number of health facilities providing integrated HIV services	DHIS	NASCOP
		SD4-9: Number of health facilities implementing universal precautions to prevent HIV infection		

2.3.5 Strategic Direction 5: Strengthening Research and Innovation to Inform the KASF Goals

This strategic direction emphasises identification and implementation of high impact research priorities, innovative programming, and capacity strengthening to conduct research. The following results have been defined by KASF:

- Increased evidence-based planning, programming, and policy changes by 50%
- Increased implementation of research on the identified KASF-related HIV priorities by 50%
- Increased capacity to conduct HIV research at national and county levels by 10%

Table 6 outlines the KASF Results, Intervention Delivery Area and the related four (4) core indicators that will be used to track the results of Strategic Direction 5, sources of data and the institutions responsible for reporting.

Table 6: Indicators for Strategic Direction 5 - Strengthening Research and Innovation to Inform the KASF Goals

KASF Result	Intervention Delivery Area	Indicator	Source	Responsible Institution
Increased capacity to conduct HIV research at country and county level by 10%	Capacity for Research	***SD5-1:*** Number of prioritized biomedical and behavioral research conducted	HIV research hub	NACC
		SD5-2: Number of people trained in HIV related research	HIV research hub	
		SD5-3: Proportion of research reports available to public	HIV research hub	
		SD5-4: Number of HIV related studies undertaken at postgraduate levels in tertiary institutions	National Council for Science and Technology	
	Funding for Research	***SD5-5***: Proportion of HIV funds utilised on research	KNASA	
Increased implementation of research on identified KASF-related HIV priorities by 50%	Implementation of Research	***SD5-6:*** Percentage of planned research implemented in line with the research agenda and KASF priorities at national and county levels	HIV research hub	NACC
Increased evidence-based planning, programming and policy changes	Application of Research Findings in Decision Making	***SD5-7***: Number of research products disseminated to inform policy, planning and programming	Biennial HIV Research Report	NACC

2.3.6 Strategic Direction 6: Promote Use of Strategic Information for Research and Monitoring and Evaluation to Enhance Programming

This strategic direction is meant to achieve the following expected results:

- Increased availability of strategic information to inform the HIV response at national and county levels
- Planned evaluations, reviews and surveys implemented and results disseminated in a timely manner
- M&E information hubs established at national and county levels
- Comprehensive information package on key KASF indicators provided for decision making

Table 7 outlines the four KASF Results, Intervention Delivery Areas, and the related seven (7) core indicators that will be used to track the results of Strategic Direction 6, sources of data and institutions responsible.

Table 7: Indicators for KASF Strategic Direction 6 - Promote Use of Strategic Information for Research and Monitoring and Evaluation to Enhance Programming

KASF Result	Intervention Delivery Area	Indicator	Source	Responsible Institution
Increased availability of strategic information to inform HIV response at national and county levels	Access to Strategic Information	***SD6-1:*** Percentage of planned M&E reports generated at national and county levels	Biennial HIV reports	NACC
		SD6-2: Percentage of planned M&E reports disseminated at national and county levels		
		SD6-3: Number of counties with functional HIV Dashboards		
Planned evaluations, reviews, surveys implemented and results disseminated in timely manner	Implementing M&E Activities as Planned	***SD6-4:*** Percentage of planned evaluations, reviews, and surveys conducted in line with set timelines	Biennial HIV Reports	NACC
M&E information hubs established at national and county levels	Establishment and Linkage of M&E Hubs	***SD6-5:*** Number of M&E Hubs established at national and county levels	Annual HIV reports	NACC
		SD6-6: Proportion of counties linked to the HIV M&E system at the national level	County HIV reporting	NACC
Comprehensive information package on key KASF indicators provided for decision making	County, Private Sector, Public Sector and Development and Implementing Partners M&E Reporting	***SD6-7:*** Number of counties with KASF monitoring committees	County HIV reporting	NACC
		SD6-8: Number of counties submitting timely, complete, and accurate reports based on targets set in their HIV plans	County HIV reporting	NACC
		SD6-9: Number of county MDAs submitting timely, complete, and accurate reports based on targets set in their HIV plans	County HIV reporting	NACC
		SD6-10: Number of private sector entities submitting timely, complete, and accurate reports	Private sector reporting	NACC
		SD6-11: Number of implementing and development partners submitting timely, complete, and accurate reports	HIPOS	NACC
		SD6-12: Number of national government MDAs submitting timely, complete, and accurate reports reporting based on targets set in their HIV plans	Programme Records	NACC
	Operationalisation of M&E Hubs	***SD6-13:*** Number of M&E Hubs with comprehensive and up to date information on KASF Indicators	Biennial HIV Reports	NACC

2.3.7 Strategic Direction 7: Increase Domestic Financing for a Sustainable HIV Response

This strategic direction aims to increase domestic financing for the HIV response to 50% to ensure its sustainability. Table 8 outlines the KASF results, intervention delivery areas and the related eight (8) core indicators that will be used to track the results of this strategic direction, sources of data and the institutions responsible for reporting.

Table 8: Indicators for KASF Strategic Direction 7 - Increase Domestic Financing of a Sustainable HIV Response

KASF Result	Intervention Delivery Area	Indicator	Source	Responsible Institution
Increase domestic financing for HIV response to 50%	Government and Non-Government Funding	***SD7-1:*** Percentage of government funding out of the total for the HIV response	KNASA	NACC
		SD7-2: Number of counties with specific budget lines and funding for HIV	KNASA and Annual County Reports	NACC
		SD7-3: Percentage of HIV domestic funding coming from private sector, including households	KNASA	NACC
		SD7-4: Percentage of HIV domestic funding coming from the public sector		
		SD7-5: Percentage HIV spending by programme area		
		SD7-6: Proportion of funds allocation to KASF by strategic direction	KNASA	NACC
	HIV Investment Fund	***SD7-7:*** HIV investment fund (trust fund) in place and operational	KNASA	NACC
		SD7-8: Total capitation of the HIV investment fund (trust fund)	KNASA	NACC

2.3.8 Strategic Direction 8: Promoting Accountable Leadership for Delivery of the KASF Results by All Sectors

This strategic direction seeks to promote good governance practices by identifying, developing and nurturing, and harnessing effective and committed leadership for the HIV and AIDS response. In this area, KASF has defined the following result areas:

- Good governance practices and accountable leadership entrenched in the multi-sectoral HIV and AIDS response at all levels
- Effective and well-functioning stakeholder co-ordination and accountability mechanisms in place and fully operationalised at national and county levels
- An enabling policy, legal, and regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010

The results will be tracked using six (6) core indicators outlined in Table 9. The table further outlines the intervention delivery areas, sources of data, and the institutions responsible for reporting.

Table 9: Indicators for KASF Strategic Direction 8 - Promoting Accountable Leadership for Delivery of the KASF Results by All Sectors and Actors

KASF Result	Intervention Delivery Area	Indicator	Data Source	Responsible Institution
Good governance practices and accountable leadership entrenched in the multi-sectoral HIV and AIDS response at all levels	Governance and Accountability for Multi-sectoral Response	***SD8-1:*** National composite policy instrument (NCPI) rating on political support for HIV and AIDS response	NCPI report	NACC
Effective and well-functioning stakeholder coordination and accountability mechanisms in place and fully operationalised at national and county levels	Coordination and Accountability Mechanisms	***SD8-2:*** Number of implementing organisations reporting at county and national levels as per M&E guidelines	COBPAR	NACC
		SD8-3: Number of counties with county HIV coordination units	County HIV Annual Reports	NACC
		SD8-4: Number of counties with functional county KASF monitoring committees	County HIV Annual Reports	NACC
		SD8-5: Number of counties with functional county HIV interagency coordinating committees (ICCs)	County HIV Annual Reports	NACC
		SD8-6: Percentage of counties which have undertaken HIV programme review	County HIV Annual Reports	NACC
		SD8-7: Number of county MDAs with sector specific HIV plans	County HIV Annual Reports	NACC
An enabling policy, legal and regulatory framework for the multi-sectoral HIV and AIDS response strengthened and fully aligned to the Constitution of Kenya 2010	Policy, Legal and Regulatory Framework for Multi-sectoral Response	***SD8-8:*** Percentage of planned policy, legal and guidelines developed or reviewed	Annual KASF progress report HIV report	NACC

SECTION

03

ROUTINE DATA COLLECTION AND REPORTING

3.1 Introduction

This section details the overall common data architecture to be put in place to manage the One Country M&E Framework for KASF, the M&E sub-systems through which data will be collected, and the data flow channels within the context of the devolved government structure and a multi-sectoral HIV response.

3.2 Common Data Architecture

NACC will establish and oversee a common HIV database to ensure that information is generated, managed, and shared in a coordinated manner. The HIV database will capture data on the core indicators outlined in this framework, from routine programmatic data from the health, community, private, and public sectors, and non-routine data from evaluations, surveys, and surveillance. This will be a web-based database designed to allow access by both the national and county levels.

The capabilities of this database include:

- NACC's capability to view all data entered into the system, input national level data, import and process all data, produce reports, and provide feedback to specific stakeholders including counties and all sectors.
- Counties' capability to input, import, and analyse routine programmatic data as well as data from evaluations relevant to the respective county, produce reports, and provide feedback.
- Modules for each sector involved in the implementation of the multi-sectoral HIV response.
- Geographic information system capability that allows geospatial representation of data.
- Data capture interface for all KASF indicators.
- Access by key institutions and stakeholders with relevant rights to view, extract, or perform analyses in line with their needs and mandates.
- Data from all sub-systems reporting on KASF core indicators will converge at the common HIV database through various data flow processes and channels. The data will be entered at the national and county levels depending on the type of indicator and the reporting sub-system.

All the HIV data collection sub-systems will be automated and linked to ensure inter-operability with this HIV database. The use of electronic medical records, online reporting and other data transmission technologies will be employed to ensure that routine M&E systems are fully automated.

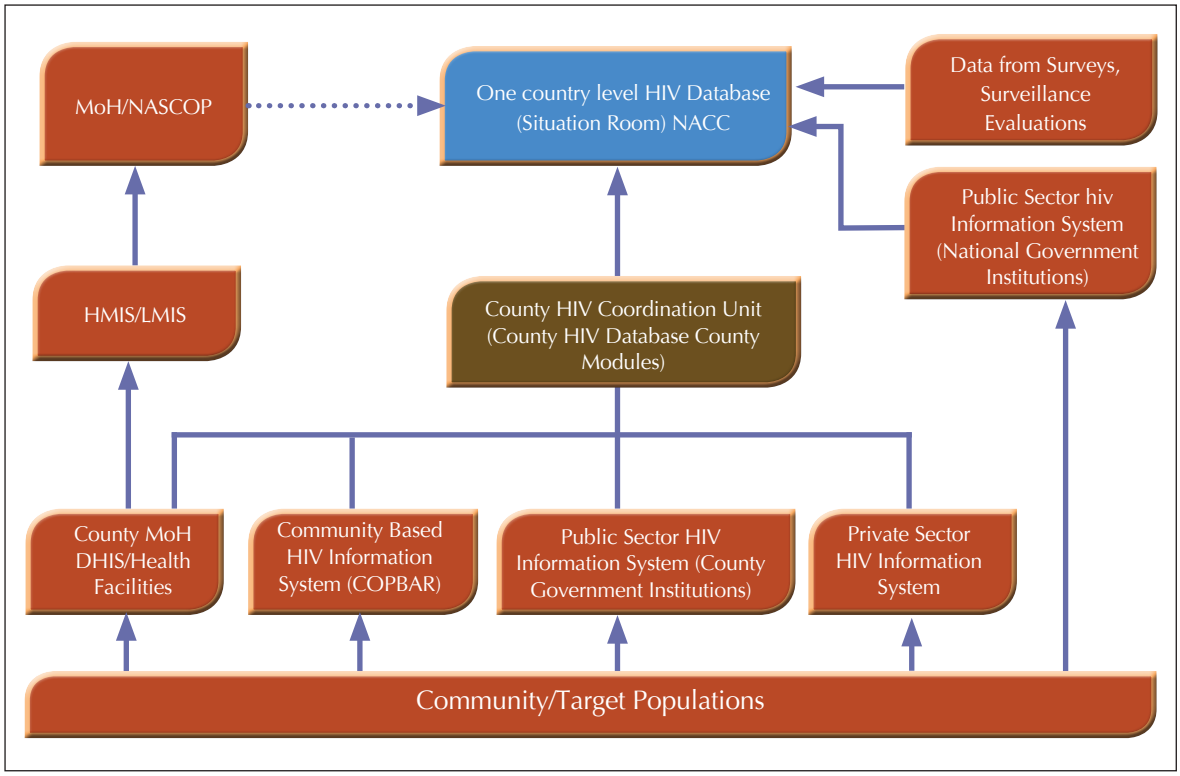
3.3 Unified HIV Response Information System

The unified HIV response information system (UHRIS) will receive data from several sub-systems that are responsible for reporting on selected KASF indicators as outlined in the *One Country M&E Framework*. The UHRIS will consolidate all the data to produce the required M&E products. The unified system will be managed using the common HIV database previously described. UHRIS supported by the HIV database will be available both at national and county levels.

The M&E sub-systems that will provide data to UHRIS include: (1) Health Management Information System (HMIS) and Logistics Management Information System (LMIS), (2) Public Sector HIV Response Reporting System, (3) Private Sector HIV Response Reporting System, and (4) COPBAR.

The following figure shows the unified HIV response information system.

Figure 1: Unified HIV Response Information Management System



3.4 M&E Sub-systems

The various sub-systems that will provide data to the unified HIV response information system are outlined below.

3.4.1 Monitoring and Reporting System for Health Sector Response

AN OVERVIEW OF HMIS AND LMIS

HMIS is a central management information system for the health sector. All health facilities submit health data to the District health information system. (formerly called DHIS). The sub-county health data is aggregated into a county health information system at the county level. This information in then reported to the national HMIS system. The MoH plans to develop a unified health information system clouding platform, which will manage this database and facilitate interaction between sub-counties and central level. This system will be used to report on the KASF biomedical indicators.

Secondly, the logistical management information system (LMIS) tracks the supply chain for pharmaceuticals and other health commodities to the health facilities. LMIS will provide data on HIV commodities stocks and supply to the health facilities.

Under KASF, county HIV coordination units will collect health sector data for analysis and use from the sub-county information systems to support decision making at that level. Data entered into systems at the county level will be made available to NACC through UHRIS. In the meantime, before this system is developed, NACC will develop a standard KASF data collation tool, which will be filled and submitted by NASCOP on a quarterly basis.

ROLES AND RESPONSIBILITIES UNDER HMIS

Table 10 outlines roles and responsibilities of various institutions that will collect and report HIV data from the health sector.

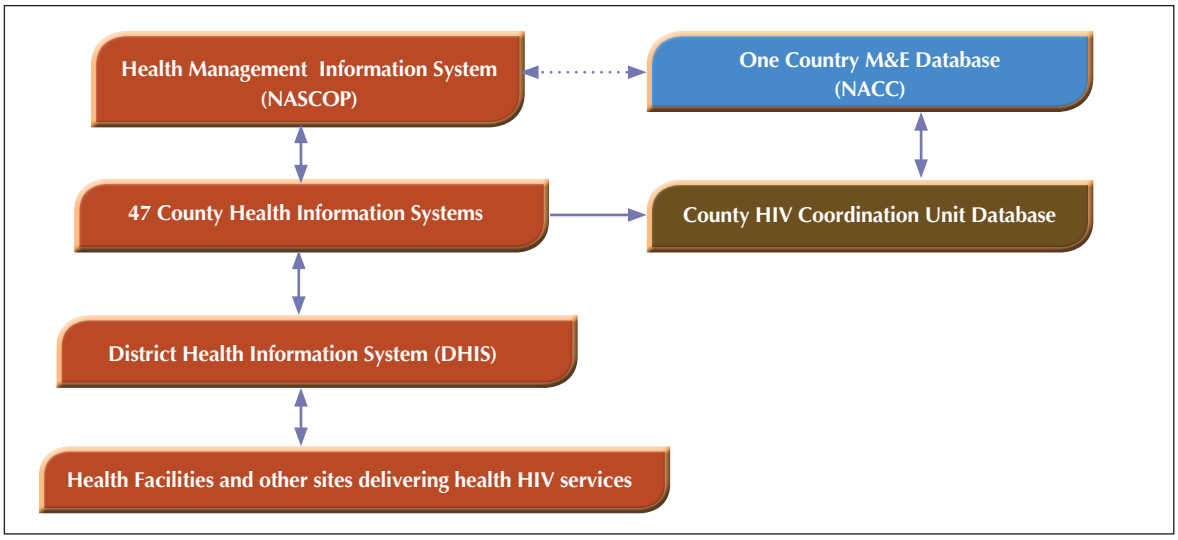
Table 10: Roles and Responsibilities for M&E Under HMIS

Institution	Role	Frequency	Reporting Tool
Service delivery points (Health facilities)	Report health sector data	Monthly	MOH 711, MOH 713
County health records and information officer	Collate health sector HIV response data	Monthly	MOH 713 - to DHIS
County HIV coordination unit and county AIDS and STI coordinating officer (CASCO)	Provide the health sector HIV response data for use at the county level	Quarterly	DHIS
MoH (NASCOP)	Review DHIS data and liaise with NACC to improve data quality	Quarterly	KASF data collation tool

DATA AND INFORMATION FLOW UNDER HMIS

The following diagram shows how data will flow from service delivery points through DHIS to HMIS. On a quarterly basis, data will be collated from the HMIS to the one country level M&E system using the KASF data collation tool.

Figure 2: Data and information flow under HMIS



3.4.2 Monitoring and Reporting System for Community-Based HIV Response

AN OVERVIEW OF THE COMMUNITY-BASED HIV INFORMATION SYSTEM

Monitoring and reporting on community-based HIV response has in the past used the COPBAR tool. Civil Society Organisations (CSOs) were required to complete the COPBAR form and submit it to NACC on quarterly basis. However, the use of the COPBAR tool faced several challenges, including: (1) low and late reporting by CSOs, especially those not funded by NACC; (2) inadequate information of the total number of organisations expected to report, hence making it difficult to assess completeness of the CSO reports as well as tracking of those who did not report; (3) inability of the system to adequately assess performance of CSOs; (4) weak data quality assurance (DQA) mechanisms integrated into the system; and (5) absence of clear structures for providing feedback to CSOs.

Under the current governance framework, a community-based HIV information system (CBIS) will be established to address some of these challenges. This system will report on mainly behavioral and structural indicators and will comprise the following key features:

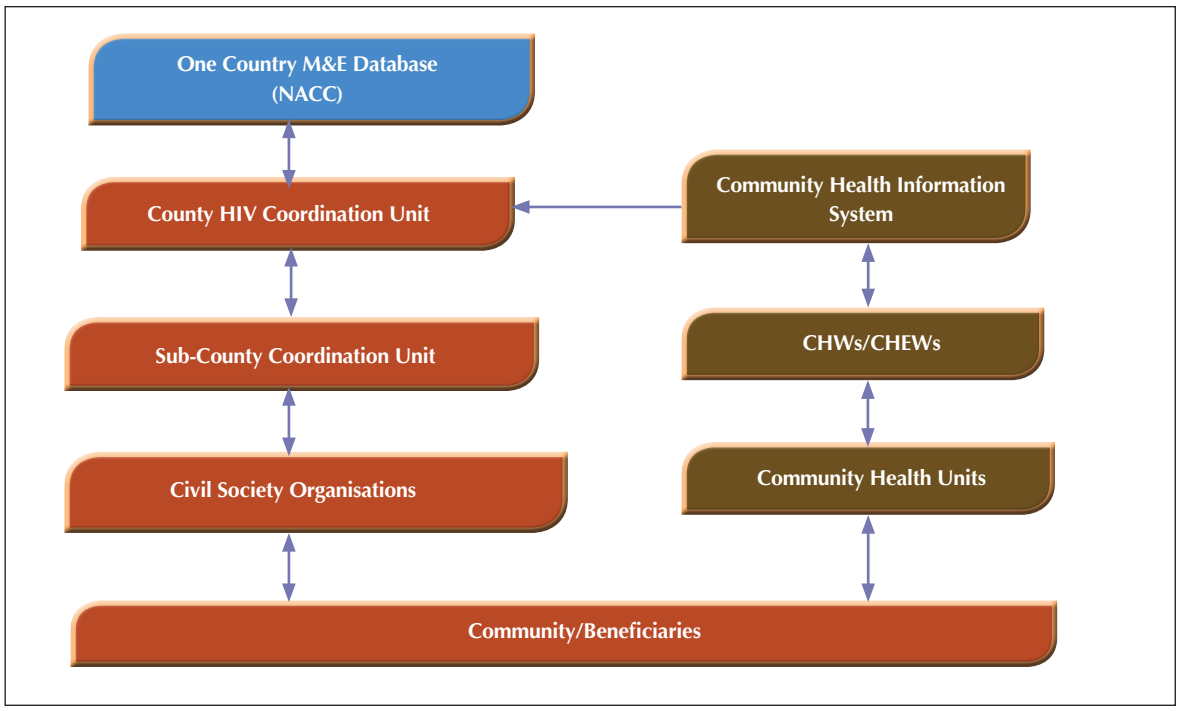
- **Database of CSOs:** The common HIV database will include a civil society organisation (CSO) module to capture all CSOs implementing HIV activities in each county. CSOs captured in the database will be expected to report on their HIV interventions based on set guidelines.
- **Community-based HIV response reporting tool:** The COPBAR tool will be revised to enable CBOs report against their planned activities and outputs. The revised tool and guidelines for completing the tool will be developed and disseminated to the CBOs.

- The COBPAR data collection will continuously move towards integration with the Community Health Information System (CHIS).
- **Interface with the CHIS:** CBIS will interface with the CHIS to ensure synergy between community health strategy and the community-based HIV response. Mechanisms to link these two systems will be explored to minimize any duplication and enable CSOs to report on interventions that support implementation of the Community Health Strategy.

DATA AND INFORMATION FLOW UNDER THE COMMUNITY-BASED INFORMATION SYSTEM

The following diagram shows the data flow from CBOs to the one country M&E system. The diagram also shows the proposed linkage with the CHIS.

Figure 3: Data and information flow for community based HIV response



3.4.3 Roles and Responsibilities

Table 11 outlines the roles and responsibilities of various institutions at the community level.

Table 11: Roles and Responsibilities of Institutions

Institution	Role	Frequency	Reporting Tool
CBOs	Report through COBPAR HIV activities implemented.	Quarterly	COBPAR
Community health worker (CHW/community health extension worker (CHEW))	Report HIV-related activities through CHIS activities.	Monthly	CHIS
County HIV coordination unit and CASCO	Receive and input COBPAR/CHIS data into the County information hub.	Quarterly	County HIV information hub

3.4.4 Monitoring and Reporting for Private Sector HIV Response

AN OVERVIEW OF THE PRIVATE SECTOR HIV INFORMATION SYSTEM

The private sector HIV response is implemented by formal and informal private sector organizations. Informal private sector entities comprise of micro and small enterprises with limited capacity to implement HIV activities on their own. These enterprises receive HIV services and support from their associations, CBOs and NGOs. On the other hand, medium and large private sector firms implement workplace HIV programmes as well as external activities targeting their customers and communities.

In line with KASF recommendation to have sector-specific interventions, a standard reporting tool will be developed to capture data from both informal and formal private sector programmes. The data will be reported to the county HIV coordination Unit and entered into the common HIV database.

ROLES AND RESPONSIBILITIES

Table 12 outlines the roles and responsibilities of various institutions that will collect and report HIV data from the private sector.

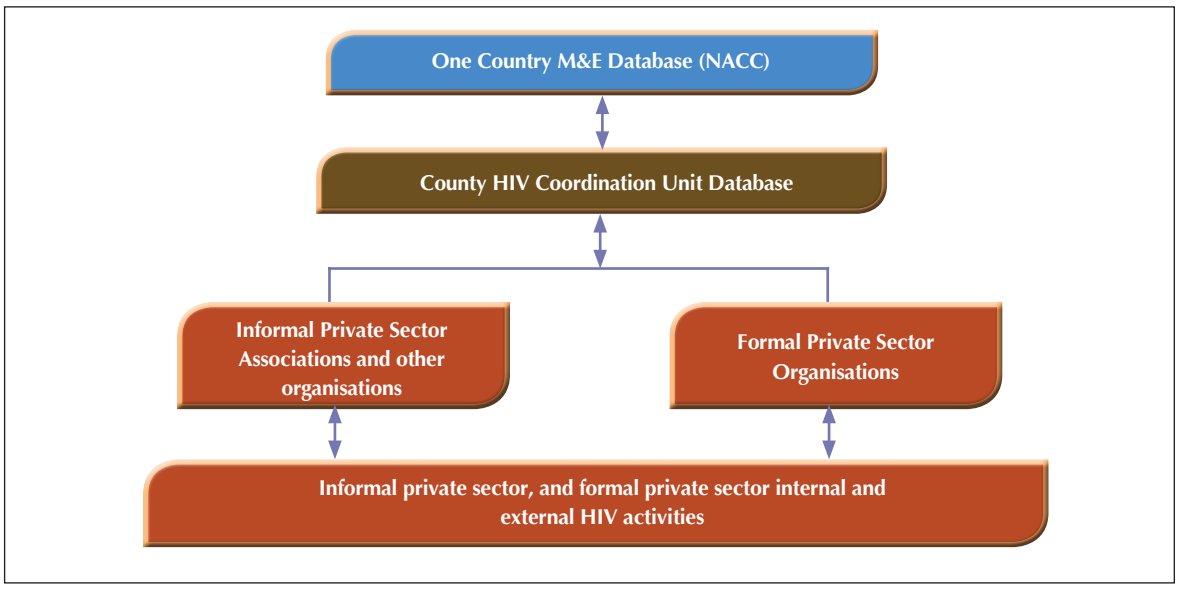
Table 12: Roles and Responsibilities of the Private Sector

Institution	Role	Frequency	Reporting Tool
Private sector organizations, associations and CBOs	Implement HIV related activities in line with their mandates Submit Report quarterly through private sector HIV response reporting tool.	Quarterly	Private sector reporting tool
National AIDS Control Council	Validate the data in the private sector database and link it to the one M&E system. Support supervision and DQA for the public sector.	Continuous	DQA plan Evaluation plan for private sector
County HIV coordination unit	Validate the county private sector data. Undertake DQA on quarterly basis and provide supportive supervision.	Quarterly	DQA plan

PRIVATE SECTOR HIV RESPONSE DATA AND INFORMATION FLOW

Private sector institutions will report on their HIV and AIDS activities using the private sector HIV reporting tool.

Figure 3: Data and information flow for private sector HIV response



3.4.5 Monitoring and Reporting system for Public Sector HIV Response

OVERVIEW OF PUBLIC SECTOR HIV INFORMATION SYSTEM

The public sector HIV response involves engagement of government ministries, departments, and agencies. Through the performance contracting process, these institutions are required to undertake and report HIV prevention activities to NACC. This M&E framework recommends the incorporation of HIV prevention into the quality management systems of all public sector institutions.

ROLES AND RESPONSIBILITIES

Table 13 defines the roles and responsibilities of various actors in the public sector in HIV reporting.

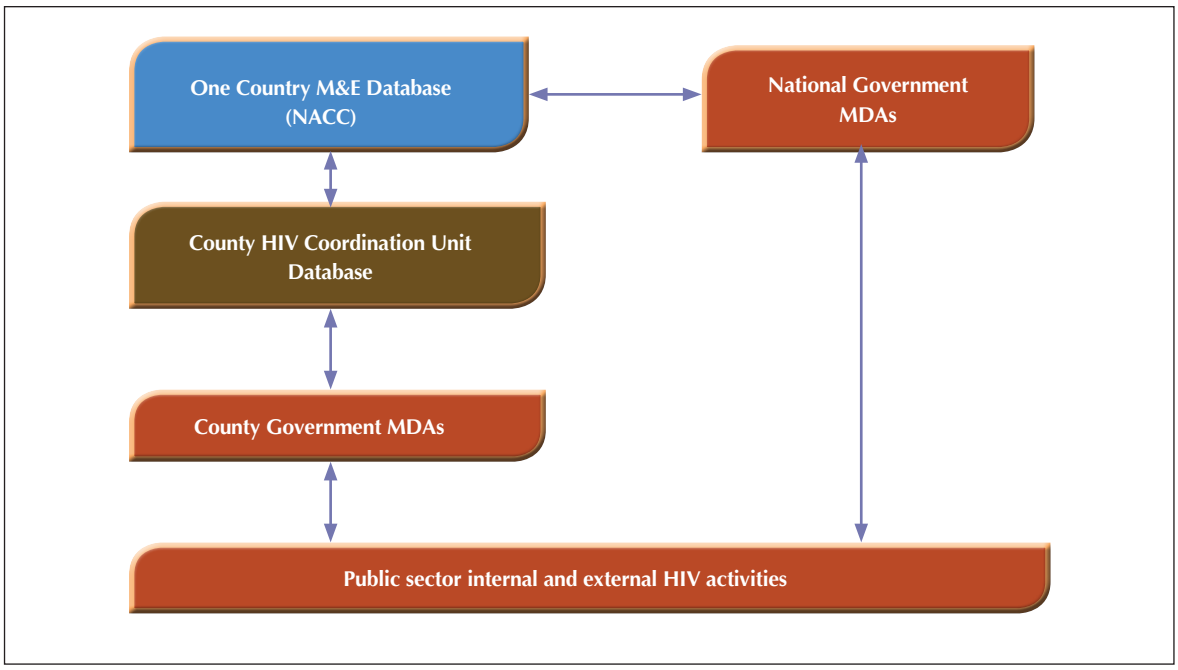
Table 13: Roles and Responsibilities of the Public Sector

Institution	Role	Frequency	Reporting Tool
Public sector institutions	Develop HIV plans in accordance with the Performance Contracting Guidelines and KASF, and submit to NACC. Report quarterly through public sector HIV response reporting tool.	Quarterly	Public sector reporting tool
National AIDS Control Council	Validate the data in the public sector database and link it to the one M&E system. Undertake performance contract evaluation as the lead agency. Support supervision and DQA for the public sector.	Continuous	DQA plan Evaluation plan
County HIV coordination unit	Validate the county public sector data. Undertake DQA on quarterly basis and provide supportive supervision.	Quarterly	DQA plan

DATA AND INFORMATION FLOW FOR PUBLIC SECTOR HIV RESPONSE

Public sector institutions will report on their HIV activities to the county HIV coordination unit and to NACC using the public sector HIV reporting tool.

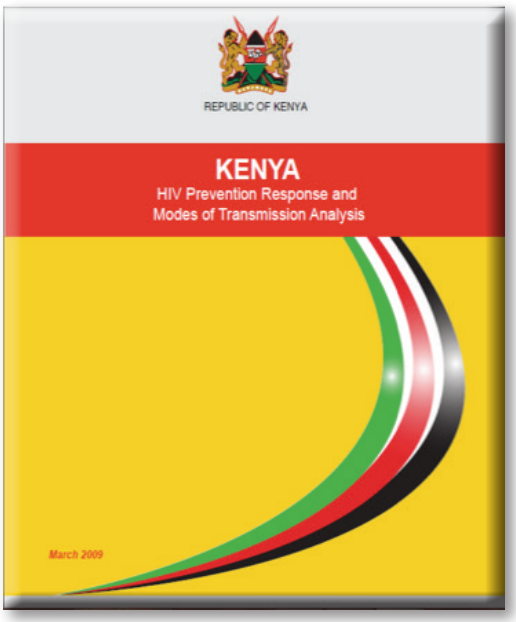
Figure 3: Data and information flow for public sector HIV response

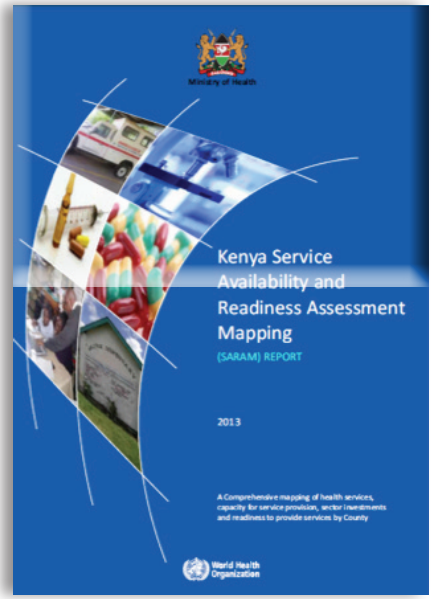


SECTION

04

SURVEYS, SURVEILLANCE AND EVALUATIONS





4.1 Introduction

This section outlines the surveys, surveillance and evaluations that will provide data for KASF outcomes and impact indicators and the years when they will be undertaken.

4.2 Surveys

Surveys will be undertaken to assess the impact and outcome of the KASF and changes in the HIV epidemic. The surveys will inform realignment of KASF given the nature of the epidemic. All surveys will have sufficient sample to enable county level data analysis. The following surveys are planned for the period 2014/2015 and 2018/2019.

4.2.1 Kenya Demographic and Health Survey (KDHS)

KDHS is a national representative household survey that provides data on a wide range of indicators in the areas of population, health, HIV and nutrition. This population-based survey is carried out every 5 years and includes an HIV module on knowledge, attitude and practices. Biomarker sample collection for HIV testing is a requirement for all subsequent KDHS. The last KDHS was conducted in 2013/14. Hence, the next one should be conducted in 2018/19 and will inform the end-of-term review of KASF.

4.2.2 Kenya AIDS Indicator Survey (KAIS)

KAIS is a population-based survey undertaken every 5 years and designed to monitor and measure progress of the country HIV and AIDS programmes. The first and second KAIS were undertaken in 2007 and 2012, respectively. In order to inform KASF mid-term evaluation, the third KAIS shall be scheduled for 2016/2017.

4.2.3 Integrated Biological and Behavioural Survey (IBBS)

IBBS is a survey conducted every year with the purpose of generating evidence on HIV prevalence and risk behaviors among key and priority populations by collecting data on prevalence, knowledge, behavior, stigma and discrimination relevant to the HIV epidemic.

4.2.4 HIV-Related Stigma and Discrimination Survey

This is a nationally sample survey conducted every 2 years that seeks to establish the knowledge of HIV-related stigma and discrimination and attitudes towards people infected and affected by HIV. The next survey will be conducted in 2016.

4.2.5 Key and Priority Populations Size Estimation

Key population size estimates are approximations developed every 2 years and used to measure and understand the impact and magnitude of HIV among key populations (sex workers, MSM, and people who inject drugs). These estimates will be updated every 2 years using primary and secondary data sources to support HIV service delivery to these groups.

4.2.6 Kenya National AIDS Spending Assessment (KNASA)

This assessment will be conducted every 2 years to measure and determine resource allocation, main sources of funds, channels of flow of funds and areas of spending for HIV response at national and county levels. The results of the survey will be used to inform resource allocation to various HIV programmes against the KASF priorities.

4.2.7 Kenya Service Provision Assessment

This is a survey carried out every 5 years by the National Council for Population and Development (NCPD) and is designed to provide national and county information on the capacity, availability, and quality of services at health facilities.

4.2.8 Service Availability and Readiness Assessment Mapping

This is a census conducted every five years by the MoH on health facilities to determine infrastructure, service availability, quality of services and staffing levels.

4.3 HIV Surveillance

HIV surveillance will be undertaken to provide information on trends of the HIV epidemic and behaviour among the general population and key populations. The sentinel surveillance remains the most developed and extensive type of surveillance being undertaken in the country. Under the KASF, the scope of surveillance will be expanded to cover key populations, women and girls.

4.3.1 ANC Sentinel Surveillance

Sentinel surveillance is conducted annually by the MoH and collects sero-prevalence data among women attending ANC clinics during pregnancy. This surveillance will be used to continually monitor the trends of the HIV epidemic among pregnant women as a proxy for HIV prevalence in the general population. With improvement of PMTCT data, this surveillance system will be reviewed continually to determine its relevance. The ANC will continue until the point where the PMTCT can be reliably utilised.

4.3.2 Routine PMTCT Data for Surveillance

Scale-up of PMTCT services has led to improved uptake of HIV testing among pregnant women and increased availability of PMTCT data. The PMTCT data will be compared with the sentinel surveillance data in order for the country to decide whether to transition to the use of PMTCT surveillance.

4.3.3 HIV Drug Resistance Surveillance

The country will continually conduct surveillance for early warning indicators for HIV acquired and transmitted drug resistance from selected sentinel sites. This surveillance will be undertaken by the MoH with the support of relevant development partners.

4.3.4 Demographic Surveillance Surveys

The country will collaborate with the existing surveillance sites to continually collect data relevant for KASF monitoring, including mortality surveillance. Kenya has three full-pledged Health and Demographic surveillance sites (HDSS) which include Kilifi, Nairobi and Kisumu HDSS sites.

4.4 HIV Epidemic Modelling for Estimation

4.4.1 National HIV Estimates

The Estimation and Projection Package/Spectrum software will be used to generate national and county HIV estimates annually. This information will inform the Global AIDS Response Progress Report (GARPR), in addition to national and county level estimates to facilitate HIV programming and assessment of the impact on the population.

4.4.2 Modes of Transmission Study

This is an incidence study conducted every 2 to 3 years based on availability of new population survey data. The study provides information on the contribution of each population group to the annual number of new adult infections. This information is key in determining the contribution of key and priority populations to the total number of new HIV infections.

4.5 Evaluations

To assess the effectiveness, impact and sustainability of KASF, mid-term, end-term and programme evaluations will be conducted.

4.5.1 Programme Evaluation

Programme evaluations will be used to establish the effectiveness and efficiency of HIV programmes. An evaluation agenda for KASF will be developed to come up with programme-specific assessments during the period of KASF implementation.

4.5.2 Mid-Term Evaluation of KASF

A mid-term evaluation to be undertaken by external independent experts will be scheduled for 2017. This evaluation will assess the relevance, effectiveness, and efficiency of the strategic framework. A detailed evaluation protocol will be developed to ascertain the achievements against what was planned. Findings of this evaluation will inform the review of the strategic framework.

4.5.3 End-Term Evaluation of the KASF

This evaluation will be conducted by independent experts and will focus on the extent to which the KASF impact and outcome results have been achieved over the implementation period. This evaluation is scheduled for 2019, and the findings will be expected to inform the development of the next strategic framework.

4.6 Timeframes for the Surveys, Evaluations and Surveillance

Table 14 shows the timeframes for conducting the surveys, surveillance, and evaluations.

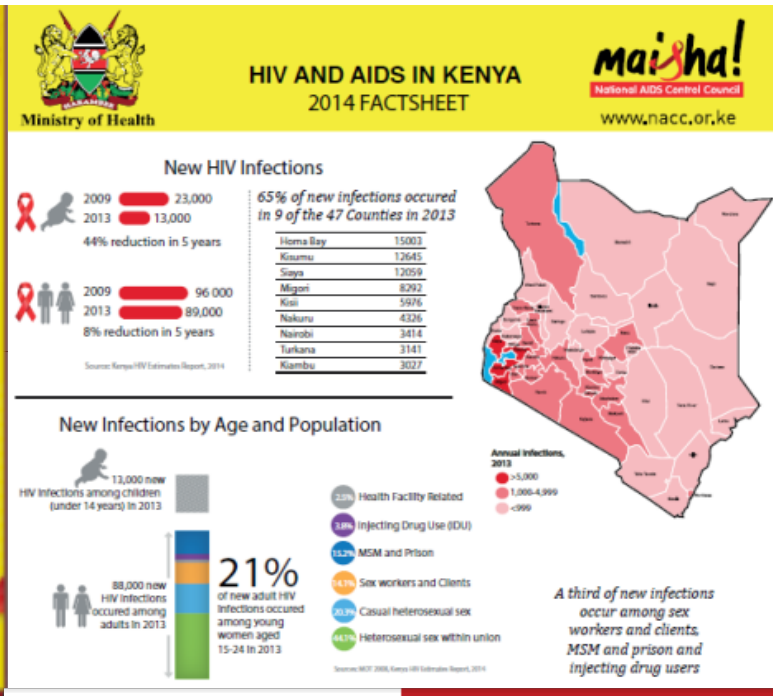
Table 14: Timeframes for Surveys, Surveillance, and Evaluations

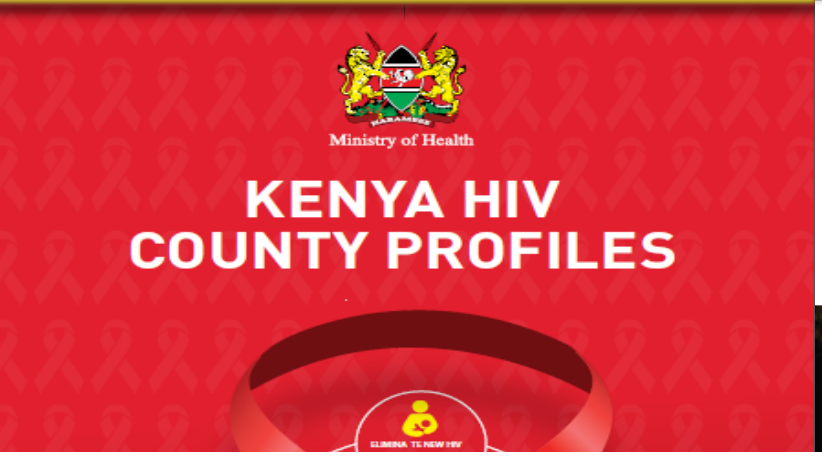
		Timeframe					Lead Institution
		2015	2016	2017	2018	2019	
Surveys							
1	Kenya Demographic and Health Survey					X	Kenya National Bureau of Statistics
2	Kenya AIDS Indicators Survey			X			NASCOP
3	Integrated Behavioural Surveillance Survey	X	X	X	X	X	NACC
4	IBBS targeting key populations	X	X	X	X	X	NASCOP
5	PLHIV stigma and discrimination survey		X			X	NACC
6	Key populations population size estimation	X				X	NASCOP
7	Kenya AIDS spending assessment	X		X		X	NACC
8	Kenya Service Provision Assessment	X					NCPD
9	SARAM				X		MoH
Surveillance							
10	ANC surveillance	X	X	X	X	X	NASCOP
11	PMTCT data for surveillance	X	X	X	X	X	NASCOP
12	Surveillance for HIV drug resistance	X	X	X	X	X	NASCOP
HIV Epidemic Modeling for Estimation							
13	HIV estimation through Spectrum	X	X	X	X	X	NACC
14	Modes of transmission study	X			X		NACC
Evaluations							
15	Program evaluations	X	X	X	X	X	NASCOP
16	Mid-term evaluation of KASF			X			NACC
17	End-term evaluation of KASF					X	NACC

SECTION

05

STRATEGIC INFORMATION DISSEMINATION AND USE





5.1 Introduction

This section outlines the M&E information products that will be developed and the dissemination that will be undertaken to inform decision making and learning. A wide range of information products will be produced at different points to meet information needs of various stakeholders. These include:

1. Consolidated biannual HIV M&E report
2. Annual HIV M&E consolidated report
3. HIV estimates and county HIV profiles
4. Global AIDs response progress reports
5. Evaluation and survey reports

5.2 M&E Data Use

M&E data and the information products generated will be used at various levels:

1. **Implementing organisations:** The first level of data use will be at the implementers' stage. The entities at this level include sub-counties health management teams, civil society, and private and public sector organisations. The organisations will review and analyse the data, identify programming bottlenecks, and make adjustments to improve performance.
2. **County KASF monitoring committees:** Annual and biannual M&E consolidated HIV reports will be used by the KASF monitoring committee to review progress in KASF implementation and make recommendations to the county HIV committee. The findings from the reports will also inform the development of biannual county HIV plans. These reports include the quarterly county HIV reports, annual HIV consolidated reports, and reports on KASF surveys and evaluations.
3. **National KASF monitoring committee:** All M&E products produced at the national level will be reviewed by this committee to assess progress in the KASF implementation, identify bottlenecks and challenges, and develop possible solutions. The committee will advise the Inter-agency Coordinating Committees (ICCs) and NACC on steps to be taken to improve the implementation of the response. NACC and ICCs will identify what works, what does not work and the innovations that can be put in place to improve performance.

5.3 Feedback Mechanisms

Feedback will be provided to various levels of KASF coordination and implementation to improve delivery of HIV services. The platforms and processes for providing feedback will be as follows:

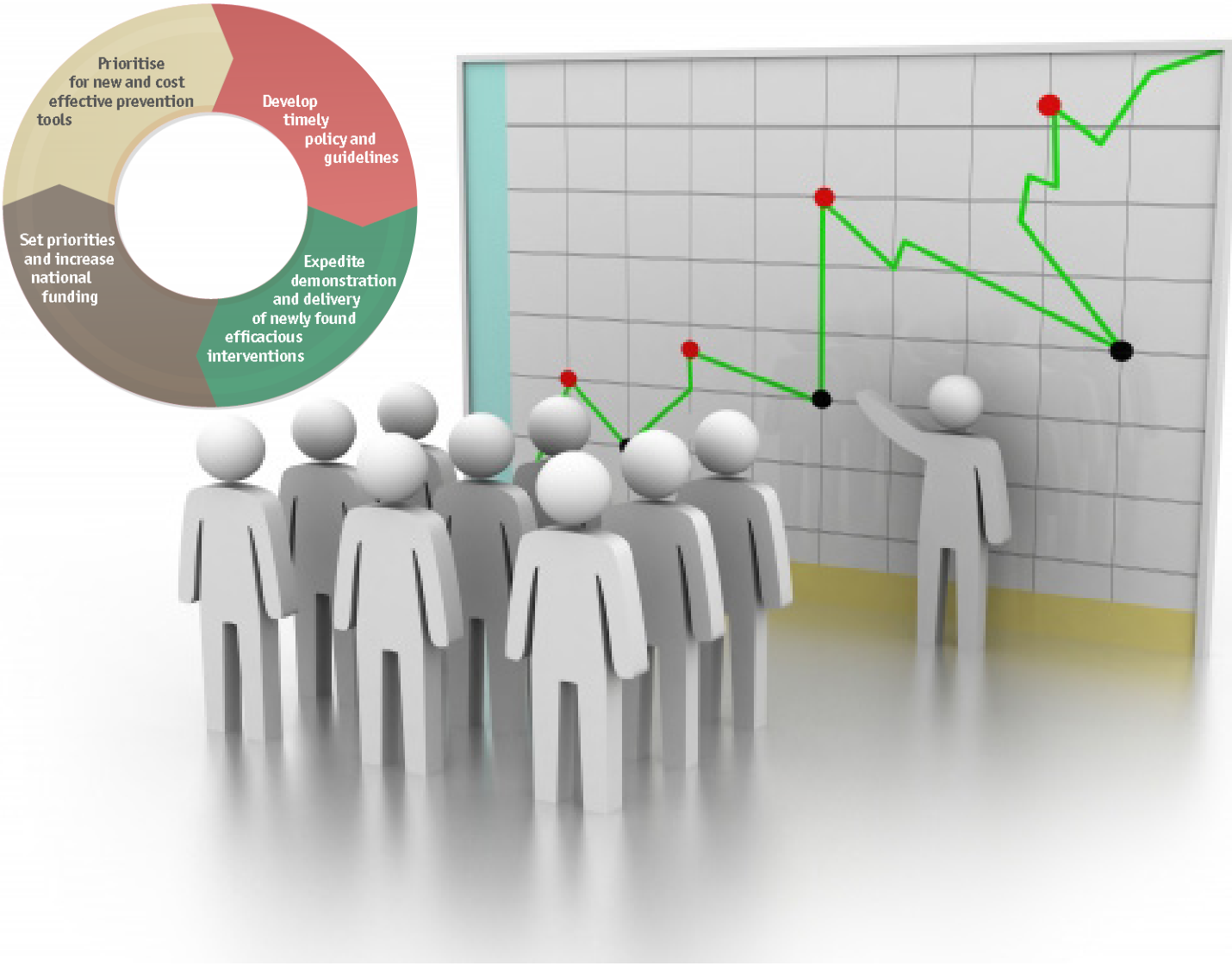
1. **Support supervision:** Counties will provide feedback to implementers during support supervision visits. The supervision visits will be informed by findings from the reports submitted by the implementing organisations, and issues identified in these reports will be addressed during the supervision visits.
2. **County HIV ICCs:** County ICCs will provide a forum for providing feedback to implementing organisations on success and challenges in KASF implementation, emerging issues, and possible solutions. The county HIV coordinating unit will present HIV reports during these committee meetings.
3. **Supportive supervision visits by NACC, NASCOP, and other national level institutions:** During these visits, feedback on progress in KASF implementation will be provided to counties and possible solutions to bottlenecks in service delivery developed.

The mechanisms for providing M&E information products dissemination and provision of feedback to various audiences are shown in Annex 1. The annex details the what, when, where, how, and by whom of the feedback mechanisms for M&E.

SECTION

06

M&E COORDINATION



6.1 Introduction

This section details the key institutional arrangements and the technical structures for stakeholder coordination on M&E at the national and county levels. These structures are aligned to the overall KASF coordination framework.

6.2 Institutional Arrangements for M&E Coordination

The institutions that will play a key role in the coordination of the implementation of this M&E framework are outlined in Table 15.

Institution	M&E Roles and Responsibilities
National AIDS Control Council	● Ensure effective coordination of the overall KASF M&E at the national and county levels. ● Develop the overall operational guidelines for the KASF M&E framework. ● Ensure effective rollout of KASF M&E framework to counties and to all sectors. ● Develop, in collaboration with counties and sectors, the community, private sector, and public sector reporting systems, including the tools and procedures. ● Ensure effective data management, including development and management of the online HIV database and automation of the community, public, and private sector response reporting systems. ● Build the capacity of counties in M&E to enable them to operationalise the KASF M&E framework. ● Lead the national KASF monitoring committee and support counties to establish and operationalise the county KASF monitoring committee. ● Coordinate KASF surveys, evaluations, and statistical modeling and facilitate dissemination of the findings to counties and other stakeholders. ● Develop and disseminate national level M&E information products. ● Ensure that all KASF M&E committees are established and operationalised at national and county levels by developing guidelines for these committees and supporting counties to operationalise the guidelines. ● Develop and operationalise the HIV Dashboard (situation room) at national and county level
MoH/NASCOP	● Ensure effective rollout and overall management of the health sector response M&E system. ● Provide technical support to counties in data collection, reporting, and analysis for health sector response M&E system. ● Review data and provide feedback to counties. ● Support counties to analyse and use data in planning for delivery of the health sector response. ● Build the capacity of counties in DQA. ● Conduct periodic data audits, develop data quality improvement plans, and monitor their implementation. ● In collaboration with NACC, KNBS, and other stakeholders, provide technical expertise and/or lead the conduct of various evaluations and surveys, including KAIS, KDHS, IBBS, and bio-behavioral surveillance survey (BSS). ● Lead the M&E sub-committee(s) for the health sector response.

Institution	M&E Roles and Responsibilities
Performance contracting office	● Review performance contract indicators on HIV prevention to ensure that adequate weighting is achieved.
County HIV coordination unit	● Overall coordination of the implementation of KASF M&E framework at county level. ● Establish and maintain the HIV implementers' database at the county level. ● Ensure effective establishment and implementation of the community, private sector, and public sector response reporting systems. ● Receive and review data from all sectors and implementers reporting at the county level. ● Manage the HIV database at the county level, including timely entry of data into the database. ● Develop county HIV reports. ● Establish and operationalise the county KASF M&E committee. ● Conduct periodic data verification and develop data quality improvement plans. ● Disseminate M&E products to all relevant audiences, including the county ICC and the county executive HIV committee. ● Provide feedback on all data received to all sectors and implementers at county level

6.3 Technical Coordination Mechanisms

The M&E technical coordination structures will include the KASF monitoring committee and ICCs at the national and county levels. The roles of these structures are outlined below.

6.3.1 National KASF Monitoring Committee

The National KASF Monitoring Committee will play the following technical roles:

- Advise on the rollout of the KASF M&E framework.
- Review M&E data to assess KASF implementation progress, identify bottlenecks, and make recommendations on possible solutions.
- Review strategic information to be disseminated to the ICCs, counties, and other stakeholders.
- Make recommendations on adjustments to KASF from time to time informed by evidence.
- Establish linkage to the county-level KASF monitoring committee to:
    - Build the M&E capacity at the county.
    - Support the operationalisation of the M&E framework by guiding the development of county M&E plans.
    - Support the county sub-committees in data analysis.

Members of this committee will be M&E experts drawn from national institutions across all sectors and partners, including public, civil society, development partners, and private sector. Key priority populations and PLHIV will also be represented. The committee shall establish M&E sub-committees for each KASF strategic direction comprising between 6 and 15 members. The National AIDS Control Council will coordinate and provide secretarial support to this committee.

6.3.2 County KASF Monitoring Committee

The county KASF M&E committee will largely play roles similar to those of the national level M&E committee, but at the county level. The roles include:

- Review and analyse data received at the county level.
- Advise the HIV coordination unit, ICC, and the county HIV executive committee (CEC) on improvement of KASF implementation at the county level.
- Facilitate the implementation of the decisions of the CEC and county HIV ICC related to HIV M&E.
- Support the overall operationalisation of the KASF M&E framework at the county level.
- Maintain linkage with the KASF M&E committee at the national level.

This committee will be convened by the county HIV coordination unit. Members of the committee will be persons with M&E expertise drawn from across all sectors and partners, including public, private, civil society and key affected populations and PLHIV from the county.

6.3.3 ICCs at National and County Levels

ICCs for HIV and AIDS existing at the national level will be maintained while the counties will establish ICCs at their level to provide a forum for stakeholders and partners to periodically review the progress in implementation of KASF within a multi-sectoral context. These committees will be partnership forums whose roles will include:

- Reviewing overall progress in implementation of KASF.
- Identifying success and challenges in implementation of the HIV response.
- Receiving and reviewing the monitoring reports for the counties (for county ICCs) and countrywide (for national ICCs).
- Building consensus on emerging issues and adjustments that need to be made to the HIV plans based on evidence.
- Promoting mutual accountability of all stakeholders.

Annex 1: M&E Products and Feedback Mechanisms

Mechanisms for dissemination of M&E products and providing feedback to various audiences are outlined in the following table.

Report	Purpose	Description of the M&E Product	Frequency of Production	Dissemination/ Feedback	Target Audience	Responsible Institution
Consolidated biannual M&E report	To provide data against outcome and output indicators of the KASF disaggregated by county and sector	A consolidated report will be produced using the data submitted to the National HIV Database, evaluation, surveys, and surveillance data.	Biannual	Biannual meetings National database County and national MoH websites	County and national governments	NACC/NASCOP
Annual HIV consolidated report	To provide the KASF implementation progress against core indicators and identify challenges and priorities for the following year	A consolidated report will be produced using the data submitted to the National HIV Database, evaluation, surveys, and surveillance data as well as Spectrum modelling data.	Annual	MoH website (NACC/NASCOP) Stakeholders' fora County and national HIV fora	County and national government County and national health stakeholders	NACC/NASCOP
County HIV profiles	To inform HIV planning and programming at the county level	County profiles provide a snapshot of the county HIV epidemic. The profiles will be developed based on routine programme data and survey findings.	2 years	MoH website (NACC/NASCOP) Public notice boards	Implementing partners County and national governments	MoH (NACC/ NASCOP) County HIV coordinating units
Global AIDS response progress report	To contribute to the development of the Global AIDS report To communicate the country progress in HIV prevention and control	This report will be produced using the data collected through the HIV M&E database and consolidated reports. The GARPR report will be produced and submitted according to the global reporting guidelines.	Annually	Situation room UNAIDs website	UNAIDS County and national governments	MoH (NACC/ NASCOP)
Evaluation and survey reports	To assess the key outcomes of KASF for planning and decision making	These are reports of all evaluations, surveys, and surveillance outlined in this M&E framework that will be produced and disseminated. These include the mid-term and end-term evaluation of the KASF, the population-based surveys, and the special evaluations and surveys such as AIDS spending, Spectrum modelling and service provision assessments.	5 years	Conferences Review meetings Stakeholders forums	County and national governments Health stakeholders	MoH (NACC/ NASCOP/ KNBS) Partners

Annex 2: KASF M&E Results Framework

	HIV indicators	Baseline	Year	Source	Mid-term (2017)	End-term (2019)
Impact results						
1	Annual number of new adult HIV infections	88,000	2013	EPP/Spectrum	44,000	22,000
2	Percentage of young women and men ages 15–24 who are HIV infected (total)	2.1%	2012	EPP/Spectrum	1.8%	1.2%
	Young women	3.0%	2012	EPP/Spectrum	2.5%	2.0%
	Young men	1.1%	2012	EPP/Spectrum	0.8%	0.5%
3	Estimated percentage of child infections from HIV-infected women delivering in the past 12 months	14.3%	2013	EPP/Spectrum	9.0%	<5.0%
4	Annual number of new child HIV infections	13,000	2013	EPP/Spectrum	6,000	3,000
5	Estimated annual number of new infections from key populations (sex workers, men who have sex with men [MSM], prison populations, people who inject drugs [PWID])	35%	2008	MoT Study	20%	15%
6	Annual number of HIV-related deaths	58,000	2013	EPP/Spectrum	45,000	30,000
7	Proportion of people living with HIV/AIDS (PLHIV) who report having experienced discriminatory attitudes	45%	2013	Stigma Index Survey		25%
8	Percentage of government funding for the HIV response	17%	2014	KNASA	30%	40%
SD 1: HIV infections among adults						
9	Percentage of young women and men ages 15–24 who have had sexual intercourse before age 15	12.7%	2012	KDHS/KAIS	8.0%	5%
10	Number of syringes distributed per person who injects drugs by the Needle and Syringe Program	25	2014	DHIS	50	75
11	Number of injecting drug users on opioid substitution therapy	22	2014	DHIS	2,000	4,000
12	Number of males circumcised as part of the minimum package for male circumcision for HIV prevention services	190,580 (77%)	2014	DHIS	200,000	200,000
13	Number of people counseled and tested for HIV and who received their test results	8,000,000	2014	DHIS	9,000,000	10,000,000
14	Number of sexual and gender based violence survivors provided with Post-exposure Prophylaxis (PEP)	40%	2013	DHIS	70%	100%
15	Number of SGBV survivors provided with Post-exposure Prophylaxis (PEP)	40%	2013	DHIS	70%	100%
16	Percentage of women and men ages 15–49 years who had sexual intercourse with more than one partner in the last 12 months	8.4%	2012	DHS/KAIS	6%	4%
17	Percentage of women and men ages 15–49 years who had sexual intercourse with more than one partner in the last 12 months reporting use of a condom during the last sexual intercourse	37.7%	2012	DHS/KAIS	50%	75%

	HIV indicators	Baseline	Year	Source	Mid-term (2017)	End-term (2019)
18	Percentage of female sex workers reporting the use of a condom during penetration sex with their most recent client	88%	2014	PBS	90%	95%
19	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	77%	2014	IBBF	80%	85%
20	Percentage of people who inject drugs who reported the use of a condom the last time they had sexual intercourse	67%	2014	PBS	70%	75%
21	Percentage of schools that provide life skills-based HIV education	100%	2013	MoE records	100%	100%
22	Percentage of health facilities providing PEP services	TBD		DHIS	100%	100%
23	Percentage of national government Ministries, Departments and Agencies (MDAs) with results-based HIV plans aligned to the Kenya AIDS Strategic Framework (KASF)	70%	2014	Public sector reporting tool	90%	100%
24	Percentage of county MDAs with results-based HIV plans aligned to KASF	0	2014	Public sector reporting tool	90%	100%
25	Percentage of national government MDAs reporting against targets set in their HIV plans	0	2014	Public sector reporting tool	100%	100%
26	Percentage of county MDAs reporting against targets set in their HIV plans	0	2014	Public sector reporting tool	90%	100%
SD 1: HIV infections—prevention of mother-to-child transmission						
27	Estimated percentage of child infections from HIV-infected women delivering in the past 12 months	14.3%	2013	EPP/Spectrum	9.0%	<5.0%
28	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV	4.5%	2013	DHIS	25%	50%
29	Percentage of infants born to HIV-infected women who receive a virological test for HIV within 2 months of birth	45.2%	2013	DHIS	70%	90%
30	Percentage of infants born to HIV-infected women starting on cotrimoxazole prophylaxis within 2 months of birth	41%		DHIS	70%	90%
31	Percentage of pregnant women who know their HIV status	92.2%	2013	DHIS	95%	95%
32	Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	55.7%		DHIS	80%	95%
33	Percentage of health facilities providing early infant diagnosis	6,780	2012	DHIS		
SD 2: Linkage to care						
34	Percentage of people diagnosed HIV positive linked to care within 3 months	TBD		DHIS		
35	Percentage of PLHIV receiving HIV care services	TBD		DHIS		
36	Percentage of adults and children enrolled in HIV care and eligible for cotrimoxazole prophlyaxis currently receiving cotrimoxazole prophlyaxis	Adults (TBD)		DHIS		
		Children (TBD)		DHIS		

	HIV indicators	Baseline	Year	Source	Mid-term (2017)	End-term (2019)
37	Percentage pregnant women newly initiated on highly active antiretroviral therapy in the last 12 months	Adults (TBD)		DHIS		
		Children (TBD)		DHIS		
SD 2: Antiretroviral treatment (ART) coverage						
38	Percentage of adults and children currently receiving ART among all eligible PLHIV (using national criteria)	Adults: 78.5%	2013	DHIS	85%	90%
		Children: 43.3%	2013	DHIS	75%	90%
39	Percentage of tuberculosis (TB)/HIV co-infected clients who are receiving antiretrovirals (ARVs)	74%	2012	DHIS	85%	90%
40	Percentage of HIV patients screened for TB	94.2%	2012	DHIS	95%	95%
SD 2: Retention on ART						
41	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART (24, 36, 60)	92.4%	2012	Cohort analysis	95%	95%
42	Percentage of ART patients with an undetectable viral load at 12 months after initiation of ART	TBD		DHIS	80%	90%
43	Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	75.4	2013	DHIS	80%	90%
44	Percentage of health facilities dispensing ART that have experienced a stock-out of at least one required antiretroviral drug in the last 12 months	0	2013	DHIS	0	0
SD 3: Self-reported stigma and discrimination						
45	Percentage of PLHIV who self-reported that they experienced discrimination and/or stigma due to their HIV status	45%		Stigma and Discrimination Index Survey Report	20%	0
46	Percentage of women and men ages 15–49 years expressing accepting attitudes toward people living with HIV	Men: 32.6%; women 46.9%	2009	KDHS	75%	80%
SD 3: Levels of sexual and gender-based violence						
47	Percentage of ever-married or partnered women and men ages 15–49 who experienced sexual and gender-based violence.	6.6%	2009	Population-based survey (DHS/ KAIS)	3%	0%
48	Percentage of young people ages 15–24 who experienced sexual and gender-based violence.	6.3%	2009	Population-based survey (DHS/ KAIS)	3%	0%
49	Percentage of PLHIV who experienced sexual and gender-based violence.	TBD		Population-based survey (DHS/ KAIS)		
50	Percentage of PWID who experienced sexual and gender-based violence.	57%	2014	PBS	30%	10%
51	Percentage of MSM who experienced sexual and gender-based violence.	24%	2014	PBS	25%	10%

	HIV indicators	Baseline	Year	Source	Mid-term (2017)	End-term (2019)
52	Percentage of sex workers who experienced sexual and gender-based violence.	44%	2014	PBS	25%	10%
53	Percentage of children who experienced sexual and gender-based violence.	22.2%	2008	KDHS	10%	0%
SD 3: Protection of human rights and improved access to justice						
54	Number of cases filed by PLHIV at the HIV tribunal	TBD		Programme records		
55	Percentage of PLHIV and key populations accessing legal services at the HIV tribunal	TBD		HIV tribunal records	50%	100%
56	Percentage of SGBV survivors accessing legal services	TBD		Judiciary records	50%	100%
57	Percentage of laws, regulations, and policies reviewed or enacted at the county level that affect the HIV response positively	0	2014	County HIV reports	50%	100%
58	Percentage of laws, regulations, and policies reviewed or enacted at the national level that affect the HIV response positively	TBD		County HIV reports	50%	100%
SD 3: Self-reported stigma and discrimination						
59	Percentage of counties implementing stigma and discrimination and gender-based violence (GBV) actions recommended in KASF	0	2014	County HIV reports	50%	100%
SD 4: Health workforce						
60	Ratio of cadres of health care staff to population in line with staffing norms	1.69/1000			2.0/1000	2.3/1000
61	Percentage of health facilities providing Kenya Essential Package for Health (KEPH)-defined HIV/AIDS services	TBD		DHIS	60%	90%
SD 4: HIV commodity management						
62	Percentage of health facilities dispensing ART that experienced a stock-out of ARVs at least once in the last 12 months	TBD		Logistics Management Information System		
SD 4: Community-level AIDS competency						
63	Number of community units implementing AIDS competency guidelines	TBD		HMIS	100%	100%
64	Number of community-based organisations that deliver non-biomedical services for HIV according to national and internally acceptable service delivery standards	7,000	2014	COBPAR	8,000	9,000
65	Percentage of community-based organisations that submit timely, complete, and accurate reports according to guidelines	47%	2014	COBPAR	75%	80%
SD 5: Capacity to conduct HIV research						
66	Number of prioritised biomedical and behavioral research studies conducted	0	2014	HIV research hub	70%	100%
67	Proportion of funds allocated to research	0	2014	KNASA	5%	7%
SD 5: Implementation of research on identified KASF-related HIV priorities						

	HIV indicators	Baseline	Year	Source	Mid-term (2017)	End-term (2019)
68	Percentage of planned research conducted in line with the research agenda at national and county levels	0	2014	HIV research hub	100%	100%
SD 5: Evidence-based planning, programming, and policy changes						
69	Proportion of research reports disseminated to inform policy, planning, and programming	0	2014	Biennial HIV Report	100%	100%
SD 6: Availability of strategic information						
70	Percentage of planned KASF M&E framework reports produced	0	2014	Biennial HIV Reports	100%	100%
SD 6: Planned evaluations, reviews, and surveys implemented and results disseminated						
71	Percentage of planned KASF M&E framework evaluations, reviews, and surveys conducted	0	2014	Biennial HIV Reports	80%	100%
SD 6: M&E information hubs established						
72	Percentage of counties linked to the HIV M&E system at the national level	0	2014	County HIV Reports	100%	100%
73	Number of counties with functional HIV M&E structure	0	2014	County HIV Reports	100%	100%
74	Number of counties submitting timely, complete, and accurate reports	0	2014	County HIV Reports	100%	100%
SD 7: Domestic financing						
75	Percentage of government funding for the HIV response	17%	2014	KNASA	30%	40%
76	Percentage of private/household funding of HIV response	13%	2014	KNASA	10%	10%
77	Percentage of funds allocation to KASF priorities	TBD		KNASA		
SD 8: Good governance practices and accountable leadership						
78	National composite policy instrument (NCPI) rating on political support for HIV and AIDS response	TBD		NCPI report		
SD 8: Effective and well-functioning stakeholder co-ordination and accountability mechanisms						
79	Number and percentage of implementing organizations reporting at county and national level, as per M&E guidelines	0	2014	County HIV Reports	80%	95%
80	Number of counties with county HIV coordination units	0	2014	County HIV Reports	90%	100%
81	Number of counties with functional County KASF Monitoring Committees	0	2014	County HIV Reports	90%	100%
SD 9: An enabling policy, legal, and regulatory framework						
82	Percentage of planned policy, legal, and guidelines developed or reviewed	0	2014	Annual KASF Progress Report	50%	75%
83	Number of counties with functional County HIV interagency coordinating committees	0	2014	County HIV Reports	100%	100%
84	Proportion of counties with HIV and AIDS budget lines	0	2014	County HIV Reports	100%	100%

Annex 3: National KASF Monitoring Committee/Task Force Members

	Name	Organization
1	Nduku Kilonzo	NACC
2	John Kamigwi	NACC
3	Joshua Gitonga	NACC
4	Jacob Odhiambo	NASCOP
5	Davis Kimanga	EGPAF
6	Gurumurthy Raingaiyan	UNAIDS
7	Nicholas Kweya	CDC
8	Peter Young	CDC
9	Ulrike Gilbert	UNICEF
10	George Owiso	I-TECH KENYA
11	Mercy Khasiani	NACC
12	Joyce Wamicwe	NASCOP
13	Brian Pazvakavambwa	WHO
14	Parinita Bhattacharjee	University of Manitoba
15	Prince Bahati	IAVI
16	Caroline Kithinji	KEMRI
18	Samuel Mwalili	CDC
19	Onesmus Mlewa	KANCO
20	Saade Abdalla	UNODC
21	Geoffrey Okumu	UNFPA
22	Dickson A Makuba	KNBS
23	Julius Nguku	HOPE WORLD WIDE
25	Stephen Mbaabu	LVCT
26	Steven Wanyee	ITECH-KENYA
27	Lily Mulei	CHS Kenya
28	Beth Gikonyo	AMREF Health Africa
29	Lize Ojowi	USAID
30	Ruth Masha	UNAIDS
31	Tom Oluoch	CDC
32	Fridah Muinde	NACC

maisha!
National AIDS Control Council
www.nacc.or.ke

NASCOP

National AIDS Control Council
Landmark Plaza, 9th Floor, Argwings Kodhek Road, P.O. Box 61307 - 00200 Nairobi, Kenya
Tel: 254 (020) 2896000, 2711261
Fax: 254 (020) 2711231, 2711072
E-mail: communication@nacc.or.ke